RESEARCH BRIEF

Perceptions of Male Involvement in the Prevention of Mother-to-Child Transmission of HIV (PMTCT) Services in the Democratic Republic of Congo

OPPORTUNITIES FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

FEBRUARY 2014

C-CHANGE
COMMUNICATION FOR CHANGE

Democratic Republic of Congo
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
CD4	Cluster of Differentiation 4 (type of white blood cell)
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
FGD	Focus group discussion
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
IDI	In-depth interview
MTCT	Mother-to-child-transmission
NGO	Non-governmental organization
PLWHA	Person living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PNMLS	Programme National Multisectoriel de Lutte contre le SIDA [National Multi-sectoral HIV/AIDS Prevention Program]
SBCC	Social and Behavior Change Communication
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

BACKGROUND AND RATIONALE

The Democratic Republic of Congo (DRC) is one of the largest countries in Africa, with an estimated population of 68–80 million people.[1] Each year this population includes approximately 2.5 million pregnant women.[2] The estimated HIV prevalence in DRC is relatively low compared to other African countries. According to the 2013–2014 Demographic and Health Survey (DHS) only 1.2 percent of the general population is infected.[3] Nevertheless, this translates into a large number of people. In 2010, there were an estimated 978,458 people in the DRC living with HIV/AIDS (PLWHAs), including 565,155 women and 168,384 children.[4]

Although mother-to-child transmission (MTCT) of HIV is completely preventable, it is the most common way children become infected. In the absence of any intervention, the risk of MTCT ranges from 15 percent to 45 percent globally.[5] Modeling studies conducted in the DRC have estimated the rate in that country to be 30.5 percent.[6] MTCT can take place during pregnancy, childbirth, or through breastfeeding.[7]

According to the World Health Organization, comprehensive programs to address prevention of mother-to-child transmission (PMTCT) of HIV include four pillars: 1) primary prevention of HIV in women of reproductive age; 2) reducing unmet need for family planning among HIV-positive women; 3) preventing HIV transmission from HIV-positive women to their infants; and 4) providing care, treatment, and support to HIV-positive women and their children and families.[8]

In the DRC there is an almost complete lack of PMTCT services, and the country has one of the lowest PMTCT coverage rates in sub-Saharan Africa. The few available services are offered through selected antenatal care (ANC) facilities, are generally concentrated in certain health zones, and are largely supported by donor funding. As of 2010, only 851 health facilities in DRC (11.3 percent) had integrated PMTCT into their services and less than half (40.4 percent) of those offered Voluntary Counseling and Testing (VCT).[10] Only 1 percent of ANC facilities had sufficient numbers of staff trained in PMTCT.[9] As a result, just 2.2 percent of pregnant women received some aspect of PMTCT services such as testing, counseling, ARV treatment, or other care. Only about half of pregnant women in 2010 who receive a test and were positive for HIV received Antiretroviral Therapy (ART).[11]

Not surprisingly, PMTCT knowledge and HIV testing levels are very low in DRC. According to the 2013–2014 DHS, only 26 percent of women and 23 percent of men knew that HIV can be transmitted through breastmilk and that the risk of MTCT can be reduced by taking medicine during pregnancy. Over three quarters (78 percent) of women of reproductive age had never been tested for HIV, and only 28 percent had received HIV counseling during an ANC visit.

[i] Ministre de la Santé Publique. Le Plan Stratégique National de Planification Familiale 2014–2020. Accessed at http://planificationfamiliale-rdc.net/plan-strategique.php.

[2] PNMLS. Plan d'élimination de la transmission du VIH de la mère à l'enfant et du maintien des mères en vie: 2012-2017. Accessed at http://emtct-iatt.org/wp-content/uploads/2012/11/PLAN-ELIMINATION-ETME-RDC-Version-finale-070120131.pdf.

[3] Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) and ICF International. 2014. Democratic Republic of Congo Demographic and Health Survey 2013–14. Rockville, Maryland, USA: MPSMRM, MSP and ICF International.

[4] PNMLS. Plan d'élimination de la transmission du VIH de la mère à l'enfant et du maintien des mères en vie: 2012-2017. Accessed at http://emtct-iatt.org/wp-content/uploads/2012/11/PLAN-ELIMINATION-ETME-RDC-Version-finale-070120131.pdf.

[5] PNMLS. Plan d'élimination de la transmission du VIH de la mère à l'enfant et du maintien des mères en vie: 2012–2017. Accessed at http://emtct-iatt.org/wp-content/uploads/2012/11/PLAN-ELIMINATION-ETME-RDC-Version-finale-070120131.pdf.

[6] PNMLS. Rapport sur l'état d'avancement de la réponse à l'épidémie du VIH/SIDA. 2014. Accessed at http://www.unaids.org/sites/default/files/country/documents//COD_narrative_report_2014.pdf.

[7] AIDSinfo. Preventing Mother-to-Child Transmission of HIV. Accessed at http://aidsinfo.nih.gov.

[8] World Health Organization. PMTCT strategic vision 2010–2015: preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals. Accessed at http://www.who.int/hiv/pub/mtct/strategic_vision/en/.

[9] PNMLS. Plan d'élimination de la transmission du VIH de la mère à l'enfant et du maintien des mères en vie: 2012-2017. Accessed at http://emtct-iatt.org/wp-content/uploads/2012/11/PLAN-ELIMINATION-ETME-RDC-Version-finale-070120131.pdf.

[10] PEPFAR. (2012). DRC PMTCT Accleration Plan: President's Emergency Plan for AIDS Relief (PEPFAR).

[11] PNMLS. Plan d'élimination de la transmission du VIH de la mère à l'enfant et du maintien des mères en vie: 2012–2017. Accessed at http://emtct-iatt.org/wp-content/uploads/2012/11/PLAN-ELIMINATION-ETME-RDC-Version-finale-070120131.pdf.

According to the National Multisectoral HIV/AIDS Prevention Program (PNMLS), the numerous reasons for the low level of PMTCT expansion and uptake in DRC include the following[12]:

- The PMTCT program is implemented vertically rather than integrated within other Ministry of Health programs.
- Service-related challenges include poor treatment of women, insufficient numbers of PMTCT personnel, and frequent stock-outs of ART and VCT supplies.
- Social barriers to HIV testing include fear of stigma.
- Poverty is another barrier to access—women have to pay approximately USD 15 for CD4 tests.[13] They may also have difficulty paying for transportation to a PMTCT site.

A small study in Kinshasa confirmed many of these barriers to PMTCT services, as well as others such as the lack male partner involvement, stigma, discrimination, and beliefs in witchcraft.[14]

Some of these factors can be addressed by obtaining the support of male partners who can provide financial and moral support. The benefits of male involvement are well documented in the literature and include increased use of PMTCT services and reduction of HIV transmission to infants.[15] Women are more likely to adhere to ART if their partners are aware of their HIV status, yet many African women choose not to disclose their status due to fear of violence and other repercussions.[16]

PTMCT programs have not traditionally targeted men, however. This has limited their involvement. Additional barriers to male involvement have been identified in the literature, including their limited knowledge of PMTCT, the perception that ANC is a women's activity, stigmatization of men who do attend ANC services, men's reluctance to learn their HIV status, and the fact that the timing of ANC/PMTCT services often conflicts with men's daily activities. In addition, women may be afraid to involve their partners in PMTCT due to fear of divorce, accusations of infidelity, or stigmatization if they are found to be HIV-positive.[17,18]

The literature has also documented facilitators to male involvement in PMTCT, mostly at the health system level. These have included offering couples routine VCT as part of PMTCT services, offering VCT on weekends and during non-working hours, offering VCT outside of healthcare settings, and sending official letters from the health system to men, inviting them to participate in ANC/PMTCT services. Increasing men's knowledge of the benefits of PMTCT, and giving them sufficient time to consider PMTCT recommendations, were also found to be beneficial.[19] Unfortunately, little research has been conducted to date on male involvement in PMTCT services in the DRC. One study did show that VCT among male partners of PMTCT patients in Kinshasa increased significantly when the service was offered in bars instead of ANC clinics. It also showed that couples counseling increased significantly when offered at churches and bars, compared to health centers.[20]

In 2013, the C-Change project conducted a small qualitative study in the city of Kisangani, DRC, in order to inform the design of a communication program to increase male involvement in PMTCT programs.

RESEARCH OBJECTIVES

The study objective was to explore opinions of target populations about PMTCT and HIV, with an emphasis on male involvement. Specifically, the study aimed to:

- Evaluate knowledge, attitudes, perceptions, barriers, and behaviors regarding the

[12] Ibid.

[13] IRIN. DRC: End of mother-to-child HIV transmission still a long way off. Accessed April 24, 2012, at http://www.irinnews.org/printreport.aspx?reportid=95346.

[14] UNAIDS/Kinshasa. (2012) Processus d'évaluation rapide (PER) des obstacles sexospécifiques et culturels liés à l'utilisation des services de prévention de la transmission verticale du VIH dans les pays fortement touchés: Expérience de la République démocratique du Congo.

[15] Morfaw F. et al. Male involvement in prevention programs of mother to child transmission of HIV: a systematic review to identify barriers and facilitators. Systematic Reviews. 2013, 2(5).

[16] Ghanotakis E. et al. The importance of addressing gender inequality in efforts to end vertical transmission of HIV. Journal of the International AIDS Society. 2012, 15(Suppl 2):17385.

[17] Ibid.

[18] Ditkemena J. et al. Male partner voluntary counselling and testing associated with the antenatal services in Kinshasa, Democratic Republic of Congo: a randomized controlled trial. International Journal of STD and AIDS. 2011 March 22(3):165-70.

[19] Ibid.

[20] Ibid.

underutilization of PMTCT services, specifically with regard to prevalent gender norms and male involvement among the target audiences

- Identify factors facilitating the use of PMTCT services, such as male involvement and other strategies suggested by the community

DESIGN, METHODS, AND DATA MANAGEMENT

This qualitative study was conducted in two health zones of Kisangani: Lubunga (a rural zone) and Makiso (an urban zone). The research methods included eight focus group discussions (FGDs) and eight in-depth-interviews (IDIs) with key informants. The FGDs were conducted with two audiences:

- Women 18–39 years old who were either pregnant or breastfeeding and attending ANC clinics where PMTCT services were offered
- Male spouses/partners of women who met these criteria

The FGDs were segmented by gender and age group (18–24 years and 25–39 years). Two groups were conducted with women and men, respectively, for each age group. FGD participants were recruited with assistance from community leaders and health care providers. In each health zone, IDIs were conducted with one health care provider (doctor or nurse), one social worker, one community leader (of a church or a community-based organization working with PLWHAs), and one traditional birth attendant. Key informants were identified by local authorities using criteria provided by C-Change.

C-Change received approval for this study from the Ethical Committee of the University of Kinshasa's School of Public Health and the FHI 360 Protection of Human Subjects Committee. Participants received a transportation reimbursement of USD 5 for their participation. Participants were assigned identification numbers and false names to protect their confidentiality. No real names were used in the notes or transcripts. To further protect confidentiality, researchers were not allowed to conduct FGDs/IDIs in their own communities, and participants verbally promised not to share any information discussed in the group.

The research team received a three-day training that included a review of research objectives, research instruments, research ethics, consent procedures, how to lead a FGD/IDI, data collection, and data analysis. The training also included practice field exercises. The research instruments were field tested in a different location but with similar audiences.

Each FGD was led by a trained moderator accompanied by two note takers. All FGDs and IDIs were conducted in Swahili and audio-recorded. At the end of each day the research team reviewed, combined, and completed their notes with the assistance of the audio recordings. The recordings were downloaded into password-protected computer files each day.

During the research, the principal field investigator observed selected FGDs and IDIs to ensure that moderators were conducting them correctly, participants were being recruited correctly, and the interpretation of responses was correct. A data collection consultant stayed with the field team throughout the research to provide direct supervision and resolve any problems.

After the research was completed, audio tapes of the FGDs and IDIs were transcribed into Swahili and then translated into French for analysis. The data consultant conducted a thematic content analysis of the findings using the qualitative data analysis software ATLAS.ti. Analysis included selection, targeting, simplification, abstraction, and transformation of the data. Notes were systematically coded by word and phrase, resulting in the creation of a thematic code book. New themes and subjects were subsequently identified. Data were analyzed by target audience and then compared across the two health zones.

KEY FINDINGS

An analysis of socio-demographic characteristics of FGD respondents revealed a mix of married, co-habiting, and single women and men. A few respondents were widowed or divorced.

Knowledge of PMTCT services

When asked to define PMTCT services, the majority of urban women in both age groups said they were general women's and children's health services.

> PMTCT evaluates the state of a pregnant woman's health. At the same time, a nurse examines the position of the infant and its fetal viability. The infant is protected against diseases during pregnancy and birth.
>
> *—Urban woman aged 25–39*

A few younger, urban women were aware of the link between PMTCT and HIV prevention, as were some of the rural women in both age groups.

> It's a crucial service because it allows a woman to get prenatal care, lab tests, VCT, and a lot of other counseling needed by a pregnant woman.
>
> *–Urban woman aged 18–24*

> It's to test a pregnant woman to see if she has the AIDS virus, and if she does have it, to avoid passing it to her baby.
>
> *–Rural woman aged 25–39*

Men knew less about PMTCT, although many did know that it was a service where pregnant women could receive prenatal care. While one urban man did say that PMTCT prevents HIV transmission, the majority thought it was a health service for women that also protects children from diseases. However, some men mentioned incorrect illnesses such as malaria, cholera, and tuberculosis.

> It's an activity whereby people received bed nets for the birth. The PMTCT provides education on how to protect oneself from diseases and tells them to bring their child to the clinic to be hygienic.
>
> *–Rural man aged 18–24*

The majority of women in Makiso and a few women in Lubunga could name specific places offering PMTCT services. The vast majority of men could not name specific PMTCT sites, with the exception of a few men in Lubunga.

Both urban and rural women mentioned learning about the PMTCT services on the radio, by word of mouth, or through a community health worker during prenatal care. Urban women also mentioned television and peer educators. Men mentioned the radio, community health workers, and village/neighborhood chiefs as sources of information on PMTCT.

Key informants were generally more knowledgeable about PMTCT and able to describe the range of services offered.

> PMTCT is the prevention of HIV/AIDS transmission from mother to child. It's a way to protect the mother and her child. It's a way to protect the baby from HIV even if the mother is infected. With PMTCT, women are given counseling and care so that their baby can be born in good health.
>
> *–Community leader*

It should be noted that at least one key informant did not know what PMTCT services were, however.

Perceptions of PMTCT services

The majority of men and women did not have strong opinions about PMTCT services. In general, men thought that PMTCT services were a good idea, saying they keep babies from being infected (although they did not specify from which disease). One urban woman acknowledged that some women see the benefits of the services while others do not.

> Some women think that PMTCT doesn't make sense because they gave birth previously without any problems, and their children didn't exhibit any danger signs. On the other hand, some other women recognize the importance of these services, because they allow pregnant women to deliver well and protect their children from infections.
>
> *–Urban woman aged 18–24 years*

The majority of key informants stated that PMTCT is viewed as a service exclusively for women.

> People say that PMTCT is exclusively for pregnant women. They don't see why men would go to PMTCT. I think that there is still a lot of ignorance about PMTCT. Men say that PMTCT is for women because [HIV] is transmitted from mother to child.
>
> *–Female social worker*

When asked about the quality and accessibility of services, more rural women than urban women said it was difficult to access them, with some saying that they had never visited a PMTCT center. Some urban women said that they could access them, but they complained about the amount of time that PMTCT takes.

> PMTCT takes a lot of time and sometimes it starts very late, because we have to wait for latecomers. But in reality, we don't have any problem accessing the services.
> *–Urban woman 25–39 years*

Some key informants expressed concerns about confidentiality related to health care providers and the location of services themselves.

> There is a disadvantage when the confidentiality of an infected person can't be assured. Everyone knows where he got tested. You only have to see someone enter through a certain door and people start gossiping. People are afraid that providers won't keep the results of their test confidential. There's also the fact that the location where services are offered is not hidden. If someone stands next to the location, they can hear everything.
> *–Female health care provider*

Some men criticized PMTCT nurses, saying that they always demanded money or that they took a long time to treat women.

> Here at St. Andre, the PMTCT services are not respected. The nurses work in their houses and the first thing they do is ask for money. They give out half-pills, which will never cure a sick person.
> *–Rural man 18–24 years*

When asked what they discuss with their wives after they return from PMTCT visits, men cite a variety of topics, including medicines prescribed, the importance of hygiene and clean water, restrictions on heavy work or sexual relations, and types of food that the mother needs to eat.

> When she comes from PMTCT, she tells me that the nurse prohibited her from doing heavy work, only light work, and from having sex until she gives birth.
> *–Urban man aged 25–39 years*

When asked where PMTCT services should be offered, women in both urban and rural areas tended to mention health centers and hospitals. The confidentiality of services was also important.

> They should be offered in a secret place, not where everyone can see them.
> *–Urban woman aged 25–39 years*

Men, on the other hand, suggested a wider variety of locations including churches, in the home, at schools, in bars, and at the market.

When asked who should utilize PMTCT services, the majority of urban women said that women alone should use them. The majority of rural women, on the other hand, said that both men and women should use them.

> Mother and father together, so that you can treat the person infected or both of them if they are both infected.
> *–Rural woman 25–39 years*

The majority of both urban and rural women felt that medical personnel should administer PMTCT programs, although a few felt that community health workers could be trained to do it.

Reasons for utilization and non-utilization of PMTCT services

When men were asked why women would want to use PMTCT services, they cited information and counseling given by community health workers, the good treatment received, and the health of the unborn child. When asked what would happen if women did not use PMTCT services, some urban and rural men mentioned death of the child, poor health, and the fact that the woman wouldn't know her HIV status.

When asked why women do not use PMTCT services, some of the 25–39 year old urban women cited fear of learning their HIV status, which could provoke a negative reaction from their partner, as well as the fact that male partners don't accompany the women

to prenatal care. The fear of learning one's HIV status was echoed by some rural women. Other rural women mention not having proper clothes or shoes as well as the fear that PMTCT nurses would tell others if a woman is found to be infected.

> Some couples are afraid of learning their [HIV] status. If they knew it, death could come soon because of their worries. The husband doesn't accompany his wife to ANC or PMTCT. The woman can easily get tested, and if she is found to be positive, the nurse tells her to call her husband. The husband can become angry, which would result in a bad situation at home.
>
> *–Urban woman 25–39 years*

One of the younger rural women mentioned the shame of being known to be infected with HIV.

When men were asked why women do not use PMTCT services, they cited a lack of money, the fact that women must wait a long time at the health centers, and poor health of some women.

Key informants in the urban area listed a number of reasons that women do not use PMTCT services, such as incorrect information, fear of learning one's HIV status, poor treatment of women by health care workers, fear of negative reactions from male partners, fear of stigmatization by the woman's family, and the lack of available medicine for those who test positive for HIV.

> Incorrect information is the primary reason that people don't use PMTCT services. In addition, there are some health care providers who are indiscrete or aggressive. This doesn't encourage the utilization of PMTCT services.
>
> *–Traditional birth attendant*

Key informants in the rural area echoed these barriers and also mentioned a lack of sensitization about PMTCT, the distance from a woman's home to the PMTCT site, and the burden of domestic duties.

Men's roles in PMTCT services

According to women, men can be involved in PMTCT by encouraging their wives to get prenatal care, driving them to the PMTCT site, and reminding them of appointments. One younger woman even said that men are responsible for the consequences if they do not support their wives.

> The man has to be involved in PMTCT because he will be responsible for any complications that arise. Complications? [The woman could have a] Caesarian section, or the baby could have a high fever. If the husband doesn't want his wife to have a high-risk pregnancy, he should force her to get prenatal care and PMTCT.
>
> *–Urban woman 18–24 years*

Some male partners of 18–24 year old women in both urban and rural areas viewed their roles as paying for PMTCT services and accompanying their wives.

When asked what would motivate men to be involved in PMTCT, women cited a desire for men to learn their own HIV status. Men, on the other hand, mentioned receiving good counseling about pregnancy as the primary motivating factor.

Women listed a variety of things that would keep men from supporting their wives' participation in PMTCT services, including the fact that men view PMTCT as a woman's affair, they are busy with work, they are afraid of HIV testing, and they are ignorant.

> Sometimes, time is the problem, because PMTCT takes almost the whole day. Some men might say, "I don't have the time to devote to your PMTCT. I have to make money."
>
> *–Urban woman 18–24 years*

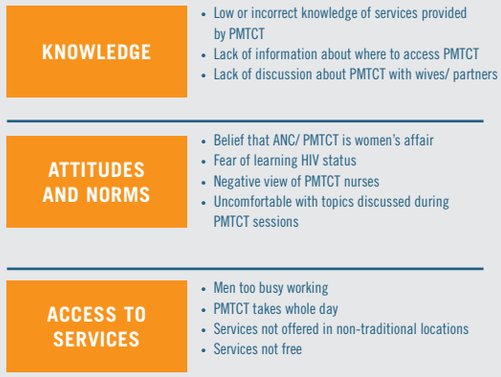
One urban woman felt that the topics discussed during PMTCT sessions might make men uncomfortable.

> Sometimes men might be uncomfortable listening to our discussions. For example: "My pregnancy is advanced and my stomach is very large, but my husband still wants to have sex with me." If a man listens to this conversation, he could be uncomfortable.
>
> *–Urban woman 18–24 years*

According to key informants, the main reason that men aren't involved in PMTCT is that it happens in the context of ANC, which is not seen as a place for men. There is also a lot of confusion about the difference between ANC and PMTCT. In addition, there is a strict division of labor between men and women, whereby men take care of supporting the family and women take care of domestic duties, childbirth, and all related activities. Therefore, men view accompanying their wives to ANC/PMTCT as a waste of time.

Figure 1 summarizes the different barriers to male involvement in PMTCT that were identified in this study.

FIGURE 1:
BARRIERS TO MALE INVOLVEMENT IN PMTCT



How to overcome PMTCT obstacles

When asked how utilization of PMTCT services could be improved, both men and women mentioned education and sensitization. Women frequently mentioned educating men.

> A woman needs to remind her husband that, "It's okay to have sex with me, but you have to feel responsible for this pregnancy and help me bring it to term" (thereby asking men to be involved in PMTCT). Nurses should invite men to PMTCT sessions.
>
> *–Urban woman 25–39 years*

Some women mentioned sensitizing nurses to make them more welcoming to poor patients.

> Nurses need to be nice when they reproach PMTCT patients who are dirty or not well dressed. Nurses need to know that poverty is not a crime and that a woman can only live with what her husband gives her.
>
> *–Urban woman 25–39 years*

When specifically asked about how to improve PMTCT services, participants mentioned the need for more discretion on the part of nurses. They also expressed a desire for PMTCT services to be free of charge.

All of these strategies—community education campaigns, reduction in cost of services, and better treatment of women by providers—were echoed by key informants. Rural informants emphasized the need to improve the services and make them more easily available.

> To attract pregnant women, services need to be high quality. Women must be treated well from the moment they walk through the door. The service needs to be truly accessible. Here the service is available… on Thursday and Saturday for pregnant women. From 8:00 a.m. to 12:00 p.m. or 1:00 p.m.
>
> *–Female health care provider*

Social and Behavior Change Communication (SBCC)

Respondents were asked their opinions about the types of SBCC activities that would be most effective for promoting PMTCT services. Women in both urban and rural areas mentioned radio and television.

> They need to organize theater skits on TV and radio to sensitize the entire family about the importance of PMTCT so that even our children can have this culture.
>
> *–Urban woman 18–24 years*

Some women and men mentioned going door-to-door to sensitize people, similar to vaccination campaigns. Other community-based channels mentioned included churches, schools, and community health workers.

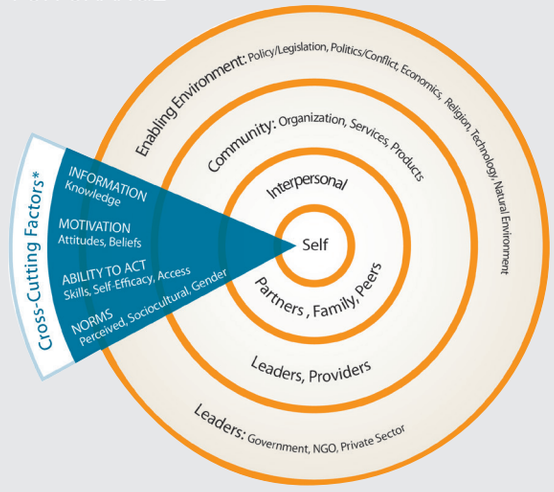
Key informants suggested SBCC campaigns specifically targeting men. They cautioned that the campaigns should include channels for reaching rural populations, who may not have access to media. They also recommended strengthening the technical capacity of PMTCT providers.

FGD participants were asked to list three words or phrases that could be used to promote PMTCT services. Most of the responses framed PMTCT as a way to support families, mothers, and children. Examples included, "A pregnant women does well with PMTCT," "PMTCT is a better future for our children," and "PMTCT supports the family."

IMPLICATIONS FOR SBCC

The findings reveal several important implications for SBCC, which can be organized according to the socio-ecological model presented in Figure 2. According to this model, a person's ability to change a behavior is influenced by factors at many different levels. Factors include information, motivation, ability to act, and social norms. An enabling environment is also crucial.

FIGURE 2:
THE SOCIO-ECOLOGICAL MODEL FOR CHANGE



*These concepts apply to all levels (people, organizations, and institutions). They were originally developed for the individual level.

SOURCE: Adapted from McKee, Manoncourt. Chin and Carnegie (2000)

Information

Many men in the FGDs knew that PMTCT had something to do with pregnancy but they often confused it with ANC. Some men did know that PMTCT involved HIV testing and treatment, but others erroneously believed that it addressed other issues such as malaria and tuberculosis. With the exception of male key informants, our research suggests that most men are not aware of the full range of services provided, and the fact that some PMTCT services like VCT are available to men. In addition, men were less knowledgeable about where to access PMTCT services in their communities than women. This could be partially due to the fact that women who receive PMTCT don't seem to discuss the experience in detail with their husbands, mentioning only general prenatal care. Increasing men's knowledge of the full suite of PMTCT services, their benefits, and where to obtain them will be important for increasing male involvement.

Motivation

Attitudes were mixed about who PMTCT services should be marketed to—some FGD respondents felt they should be marketed only to women, while others felt they should be marketed to couples. Men in this study seemed generally supportive of PMTCT services, but at least one respondent indicated that the services in his community were not respected. He also had a negative view of PMTCT nurses. This view was echoed by many women and key informants, who reported that nurses mistreat women and do not respect confidentiality. Some women felt that men might be motivated to participate in PMTCT if they were sensitized about the benefits and if they were directly invited to do so by nurses. Changing the attitudes of nurses towards PMTCT patients—especially poor women who may feel mistreated—will be critical for motivating men and women to attend PMTCT services.

Ability to act

The literature makes clear that access to PMTCT in DRC services is limited; the vast majority of health structures do not yet offer these services. Even where they are offered, such as in the two health zones in this study, they are only available a few days a week during specific hours. Especially in rural areas, couples may live far away from existing PMTCT sites and may not have the money needed for transportation. Access is further limited by the fact that PMTCT services are not entirely free and couples may not be able to afford them. Our research also revealed that attending PMTCT services often takes an entire day due to long

wait times and lack of punctuality—this poses a major barrier to men, who must spend their days working to support their families. However, the research also revealed some ways that men could become more involved in PMTCT, such as driving their wives to appointments, helping them take medicine, and paying for services. Men in this study also suggested alternate locations where PMTCT services could be offered, such as bars, markets, and churches. Providing services such as VCT in non-traditional locations, at hours convenient to working men, could increase male involvement. Advocacy for expansion of services into more communities and non-traditional settings, as well as reduction of PMTCT fees, could increase access for both men and women.

Social norms

In Congolese society, ANC and PMTCT services are considered women's affairs. Men are supposed to spend their time providing for their families, and many view accompanying their wives to the clinic as a waste of time. Men may also be ridiculed by other men if they are seen taking an active role in ANC. In addition, HIV-related stigma is a major issue in DRC, keeping many men and women from getting tested. Respondents in this study repeatedly expressed concerns about confidentiality breaches by nurses and negative or even violent reactions from partners, families, or communities. The fear of having HIV is so great that several respondents said that the fear itself could lead to early death. Communication campaigns to change community norms to make male involvement in ANC/PMTCT more acceptable and decrease HIV-related stigma will help to create an enabling environment for the utilization of PMTCT services by both women and men. Efforts to address gender-based violence (GBV) will also help men to be more supportive of women who test positive for HIV.

CONCLUSIONS AND RECOMMENDATIONS

It is clear from the literature that significant system-wide changes are needed in order to increase availability and uptake of PMTCT services in DRC. Changes include better integration with ANC services, expansion of PMTCT services (including offering VCT for men in non-traditional sites such as bars), reduction of the cost-burden placed upon PMTCT patients, increasing the quantity of trained personnel, and improving the supply chain to avoid stock-outs. SBCC programs can help to achieve these systems-level changes by advocating for increases in PMTCT funding, for better training of personnel, and for better integration of PMTCT within other health programs.

Comprehensive SBCC campaigns to change perceptions about men's involvement in ANC/PMTCT, address HIV-related stigma, and reduce GBV should be implemented in conjunction with campaigns to increase demand for PMTCT services. Utilization of PMTCT services will not increase unless these underlying norms and fears are addressed. Men also need to be viewed as important audiences in all of these efforts, given the important role that they can play in supporting their wives, partners, and newborn children. Finally, this research also revealed a clear need to improve the attitudes and communication skills of health care providers who provide PMTCT services—especially nurses. Women and men will only use PMTCT services if they feel welcome and know that their confidentiality will be guaranteed.

The development of a coordinated national PMTCT communication strategy addressing behavioral influencers at the individual, service-delivery, community, and policy levels is recommended to support PMTCT-expansion activities already being implemented by major donors, including USAID and UNAIDS. Research respondents mentioned a variety of channels that could be used to effectively reach men and women in urban and rural areas, including mass media, churches, schools, and door-to-door campaigns. Taking a 360-degree approach to advocating for expanded services, promoting PMTCT, and addressing underlying social norms related to gender perceptions of ANC, HIV stigma, and GBV will go a long way to increasing service utilization and male involvement.

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